STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING _____ B. WING _____	C 05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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F 000	INITIAL COMMENTS This visit was for Investigation of Complaint IN00090148. This survey resulted in a partially extended survey-Immediate Jeopardy of past non-compliance. Complaint IN00090148: Substantiated, Federal/State deficiencies related to the allegations are cited at F329. Survey date: May 18, 2011 Extended survey date: May 19, 2011 Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey team: Vanda Phelps, RN Census bed type: 16 SNF 147 SNF/NF 163 Total Census payor type: 15 Medicare 117 Medicaid 31 Other 163 Total Sample: 3 Supplemental sample: 3 Zionsville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 410 IAC 16. 2 in regard to the Investigation of Complaint IN00090148 which resulted in a past non-compliance immediate jeopardy. Quality review completed on May 20, 2011 by Bev Faulkner, RN.	F 000		
F 329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the	F 329	Past noncompliance: no plan of	

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F 329	Continued From page 2 facility failed to monitor and provide professional medical services to assure residents receiving anticoagulation medication received care to assure the medication level remained therapeutic and safe. This deficient practice resulted in lack of laboratory monitoring of the anticoagulant blood level for 1 of 6 residents sampled for anticoagulation therapy management between 3/17/2011 and 4/15/11. The resident was then hospitalized with extensive bruising, internal bleeding, hypotension "probably secondary to acute blood loss," and Coumadin toxicity. This deficient practice impacted 1 of 6 residents reviewed for management of anticoagulation therapy in the sample of 6. (Resident F) This deficient practice resulted in immediate jeopardy of past non-compliance. The immediate jeopardy of past non-compliance was identified on 5/19/2011 at 4:30 p.m., and began on 3/17/2011. The Administrator and the Director of Nursing were notified of the immediate jeopardy of past non-compliance on 5/19/2011 at 4:45 p.m. The immediate jeopardy was removed and corrected on 4/21/2011 at 5 p.m., when the facility implemented a new system of monitoring anticoagulation medications and ensuring laboratory values were ordered. Findings include: The closed clinical record of Resident F was reviewed on 5/18/2011 at 4:30 p.m. It indicated she was admitted to this facility from a hospital on 3/12/11. Her diagnoses included, but were not limited to, atrial fibrillation, insulin dependent diabetes, pulmonary hypertension and chronic	F 329	correction required.	

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kidney disease, stage III. She'd had a pacemaker implanted on 3/11/11. She was admitted for strengthening to return to her home where she lived independently. She had been on Coumadin, an anticoagulation medication, for about one year.

Review of the nursing notes throughout her admission of 3/12 through 4/18/11 indicated she was cognitively intact and acted as her own person legally. She required assistance for ambulation due to difficulties from chronic lower leg edema (swelling). She was receiving occupational and physical therapy in anticipation of her return home.

Further review indicated Resident F had been admitted with Coumadin (a medication that slows clotting time) 5 mg (milligrams) daily. Her first PT (prothrombin time) and INR (International Normalized Ratio) at the facility was on 3/14/11. These are blood tests that measure the time it takes the blood sample to clot
The PT had been 12.3 seconds (normal 9.9-13.3) and the INR was 1.1 ratio (normal 0.9-1.1). Her Coumadin dosage was increased to 6 mg. daily.
The next labs were dated 3/15/11. The PT was 13.5 seconds and the INR was 1.2 ratio. The Coumadin dose was increased to 7 mg. daily on 3/15/11.
On 3/17/11, the PT measured 21.2 seconds and the INR was 1.9 ratio. The nurse practitioner initialed the lab result to signal she had read it, but there were no new Coumadin orders and no orders for further lab testing. Evidence was lacking of any facility attempts to obtain an order for further PT/INRs.

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A nursing note on Friday, 4/15/11 at 10:30 a.m., indicated, "Res (resident) came to nurses station c (with) c/o (complaints of) nausea, dark stools, purple discolorations to bilateral inner forearms and L upper arms. (sic) MD notified. MD will assess resident today."
The Nurse Practitioner wrote a progress note on 4/15/11, which indicated she ordered a stat (to be done immediately) PT/ INR. The 4/15/11 PT measured the level at > (greater than)140 seconds; normal was 9.9-13.3 seconds. The INR measured >10.0 with normal defined as 0.9-1.1 ratio. The Coumadin was also discontinued on 4/15/11.

Another PT/INR was done on 4/16/11 with exactly the same readings. The nurse practitioner ordered an injection of Vitamin K and another PT/INR on 4/17/11. The 4/17/11 PT/INR was again the exact same. Another dose of Vitamin K was ordered with more labs on 4/18/11. On Monday, 4/18/11, the PT reading was 202 and the INR was at 10. Her hemoglobin reading was at 5.2; with a normal range of 11.2 - 15.7 She was sent to the emergency room.

Review of the 4/18/11 emergency room documentation was done on 5/19/11 at 1:30 p.m. It indicated Resident F was "...covered with bruises all over." The initial diagnoses were gastrointestinal hemorrhage and Coumadin poisoning. She was admitted into the intensive care unit.

Resident F was discharged from the hospital to another nursing home on 4/26/11. Her discharge summary listed the following discharge

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diagnoses:
1. acute blood loss anemia secondary to Coumadin toxicity
2. subcutaneous bleeding, left flank, bilateral arms secondary to Coumadin toxicity
3. hematoma right hip secondary to Coumadin toxicity
4. upper GI (gastrointestinal) bleeding secondary to Coumadin toxicity
5. Coumadin toxicity questionably secondary to drug interaction, probably torsemide plus fluoxetine
6. Liver dysfunction questionably secondary to statin versus shock liver secondary to #1, resolving
7. non-ST myocardial infarction secondary to #1
8. acute renal failure, prerenal, resolved
9. hypothyroidism
10. deep vein thrombosis left upper extremity probably related to recent pacemaker placement
11. difficulty walking, multifactorial
12. edema, chronic
13. diabetes mellitus on insulin
14. hypertension, controlled without medications

Interview with the Unit Manager of Resident F's stay on 5/19/11 at 3:30 p.m. indicated she assumed her duties in late April 2011. She had been in orientation starting 4/4/11.

Interview with the Director of Nursing on 5/18/11 at 6 p.m., indicated she had reviewed Resident F's record and concluded the resident's plan of care had been followed. She indicated there was no physician's order for a PT/INR between 3/17/11 and 4/15/11. She indicated there had not been a facility protocol to cue the nursing staff to request an order for labs to monitor Resident F's

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Coumadin level. However, she had met with the Nurse Practitioner on 4/18/11 and developed a protocol to share a list of the physicians' residents who were taking Coumadin and the current associated orders each month. Further, each resident on Coumadin had a tracking form in the medication administration record, which tracked the orders and lab results in a condensed format.

An immediate jeopardy of past non compliance was identified on 5/19/2011 at 4:30 p.m. The immediate jeopardy of past non-compliance began on 3/17/11 when the nurse practitioner failed to write an order for the next Coumadin monitoring labs. The Administrator and the Director of Nursing were notified of the immediate jeopardy of past non-compliance related to having a resident taking Coumadin without a physician order for associated lab tests to measure the level of the Coumadin on 5/19/11 at 4:50 p.m. The immediate jeopardy was removed and corrected on 4/21/2011 at 5 p.m., when through record review and interviews conducted 5/19/11, it was determined the facility had implemented a plan of action to monitor lab work and medications for residents receiving Coumadin.

This federal tag relates to complaint number IN00090148.

3.1-48(a)(3)